Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
512-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address

BERNIE L MCCASKILL
8220 WALNUT HILL LANE SUITE 310
DALLAS TX 75231

Respondent Name
INSURANCE CO OF THE STATE OF PA

Carrier's Austin Representative
Box Number 19

MFDR Tracking Number
M4-13-1469-01

MFDR Date Received
FEBRUARY 12, 2013

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "Rule 134.204 (e) (4) (A) states reimbursement for the treating doctor is $113.00. The charge is not included in any other service."

Amount in Dispute: $113.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The carrier asserts that is has paid according to applicable fee guidelines and challenges whether the disputed charges are consistent with applicable fee guidelines."

Response Submitted by: Flahive, Ogden & Latson

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
August 2, 2012	CPT Code 99361-W1-25	$113.00	$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving a medical fee dispute.
2. 28 Texas Administrative Code §134.204, effective March 1, 2008 sets the reimbursement guidelines for the disputed service.
3. The services in dispute were reduced/denied by the respondent with the following reason codes:

   Explanation of benefits
   - 97-The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated.
   - 150-Payer deems the information submitted does not support this level of service.

Issues

1. Does the documentation support billed service per 28 Texas Administrative Code §134.204(e)? Is the

requestor entitled to reimbursement?

Findings

1. 28 Texas Administrative Code §134.204(e) states "Case Management Responsibilities by the Treating Doctor is as follows:
   - (1)Team conferences and telephone calls shall include coordination with an interdisciplinary team.
     (B) Team conferences and telephone calls must be outside of an interdisciplinary program.

   Documentation shall include the purpose and outcome of conferences and telephone calls, and the name and specialty of each individual attending the team conference or engaged in a phone call."

   A review of the submitted report indicates "Judith Saunders acting as a medical case manager accompanies the patient to his appointment." The documentation does not indicate the purpose or outcome of the conference.

   - "(2) Team conferences and telephone calls should be triggered by a documented change in the condition of the injured employee and performed for the purpose of coordination of medical treatment and/or return to work for the injured employee."

   The case management report does not document any changes in claimant's condition or treatment plan/and or return to work to trigger a case management conference.

   - "(4) states "Case management services require the treating doctor to submit documentation that identifies any HCP that contributes to the case management activity. Case management services shall be billed and reimbursed as follows:
     (A) CPT Code 99361.

     (i) Reimbursement to the treating doctor shall be $113. Modifier 'W1' shall be added."

   The requestor billed CPT code 99361-W1-25.

   Review of the submitted documentation finds that the requestor did not support billing for case management services per 28 Texas Administrative Code §134.204(e). As a result, reimbursement is not recommended.

Conclusion

For the reasons stated above, the Division finds that the requestor has not established that additional reimbursement is due. As a result, the amount ordered is $0.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to $0.00 reimbursement for the disputed services.

Authorized Signature

Signature	Medical Fee Dispute Resolution Officer	8/22/2013 Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, effective May 31, 2012, *37 Texas Register 3833*, **applicable to disputes filed on or after June 1, 2012**.

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.